## APPENDIX 7
## PRIOR AUTHORIZATION REQUEST FORM (PA/RF) COMPLETION INSTRUCTIONS

**ELEMENT 1 - PROCESSING TYPE**
Enter "129".

**ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER**
Indicate the recipient's 10-digit Medical Assistance identification number from the recipient's Medical Assistance identification card.

**ELEMENT 3 - RECIPIENT'S NAME**
Indicate the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

**ELEMENT 4 - RECIPIENT'S ADDRESS**
Indicate the address of the recipient's place of residence; the street, city, state, and zip code. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

**ELEMENT 5 - RECIPIENT'S DATE OF BIRTH**
Indicate the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

**ELEMENT 6 - RECIPIENT'S SEX**
Indicate an "X" to specify male or female.

**ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE**
Indicate the name and complete address (street, city, state, and zip code) of the billing provider. No other information should be indicated in this element since it also serves as a return mailing label.

**ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER**
Indicate the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

**ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER**
Indicate the eight-digit Medical Assistance provider number of the billing provider.

**ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS**
Indicate the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the service requested.

**ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS**
Indicate the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description additionally descriptive of the recipient's clinical condition.

**ELEMENT 12 - START DATE OF SPELL OF ILLNESS** (not required)

**ELEMENT 13 - FIRST DATE OF TREATMENT** (not required)

**ELEMENT 14 - PROCEDURE CODE(S)**
Indicate the appropriate procedure code for each service requested in this element.

**ELEMENT 15 - MODIFIER** (not required)

**ELEMENT 16 - PLACE OF SERVICE**
Indicate the appropriate place of service code designating where the requested service would be provided.

| Code | Description |
|---|---|
| 2 | Outpatient Hospital |
| 3 | Office |

**ELEMENT 17 - TYPE OF SERVICE**
Indicate type of service code "1" to signify medical day treatment services.

**ELEMENT 18 - DESCRIPTION OF SERVICE**
Indicate a written description corresponding to the appropriate procedure code for each service requested.

**ELEMENT 19 - QUANTITY OF SERVICE REQUESTED**
Indicate the number of hours for each service requested.

**ELEMENT 20 - CHARGES**
Indicate your usual and customary charge for each service requested. If the quantity is greater than "1," multiply the quantity by the charge for each service requested. Indicate this total in element 20.

> *NOTE:* The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health and Social Services.

**ELEMENT 21 - TOTAL CHARGE**
Enter the anticipated total charge for this request.

**ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT**
"An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance managed care program at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the managed care program."

**ELEMENT 23 - DATE**
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

**ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE**
The signature of the provider requesting the service must appear in this element.

***DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER -- THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).***